Keeping Competition Fair for Health Insurance: How the Irish Beat Back Risk-Rated Policies

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Introduction

Since the 1980s, American policymakers and consulting firms have been successfully exporting to European nations and many developing countries the idea that competitive health insurance will slow down or lower health care costs. But many countries have concluded that, while competition between providers may save money, a uniform means of collecting premiums or taxes is cheaper and more equitable than having competing insurers write policies and gather the money. Nevertheless, the European Union issued a directive in 1992 that requires all nations to introduce competition among health insurers while preserving the "social good." This paper describes the efforts by Ireland to create a level playing field for such competition, the attempts by an insurer to circumvent those efforts, and the more basic policy issues raised.

Medical expenditures are so skewed that the sickest 2% of a large pool are estimated to use 41% of the total costs, and the sickest 10% consume 72%. Competing insurers can make large profits much more easily by taking in fewer than their proportionate share of these very sick people, or by inducing them to disenroll, than by producing the fruits of competition for society by becoming more efficient or providing better service. Unless careful safeguards are put in place, however, competition between health insurers obeys the inverse coverage law: the more people need insurance, the less coverage they will get and the more they will pay for what they get.

Extensive research designed to identify risk adjusters that would avoid adverse selection in competition between health insurers has failed; the "maximum explainable variance in annual acute health care expenditures per individual is around 15%," leaving at least 85% open to cream skimming. Techniques include selective denial for specific risks or disorders; higher charges for specific risks or disorders; market segmentation via policy design; market segmentation via selective marketing; front-end and back-end methods of making the sick pay more out of pocket; excluded or limited access to tests, procedures, and drugs; and procedural harassments for access to specialty services. For these and other reasons, competition in health insurance that benefits—rather than harms—society by lowering costs and improving services is difficult to attain.

Promoting Equitable Competition

In 1994, the Irish Dail (legislature) passed an act designed to foster competitive health insurance within an equitable framework centered on community rating. The act used three principles for equitable competition in health insurance: community rating, open enrollment, and lifetime coverage. That Ireland was the only member of the European Union to establish a level playing field for competition indicates the serious dangers of higher costs and greater inequities that other European nations may experience through "competition" in the years to come.

In order to understand the context, scope, and issues raised, one needs an overview of coverage and insurance in Ireland. Until the 1950s, the Irish had provided free care for the poor through the poor laws and, subsequently, local boards and county boards. The nonpoor paid private fees, but as the postwar cost of hospital-based care rose sharply, the government granted limited eligibility in 1953 for free services and established the Voluntary Health Insurance Board in 1957 as a nonprofit, quasi-public but independent body offering hospital-based insurance to those not eligible for free care. The board's policies were based on the three previously mentioned principles (i.e., community rating, open enrollment, and lifetime coverage). In 1991, hospital-based services were extended free to everyone, while primary care services remained free only to the 35% of the population eligible for low-income.

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income medical cards. Thus, the board's policies have become a community-rated upgrade for specialty and hospital services to the national health service.

In terms of equity, this arrangement is far superior to risk-rated private insurance and the upgrades that are found in many countries such as Great Britain, because it does not allow insurers to select procedures, disorders, or subscribers from the national service or system. Moreover, all the Voluntary Health Insurance Board's policies offer the same rate nationwide for each of 5 policies that have very similar coverages and differ largely in terms of the degree of private care they pay for. Coverage focuses heavily on queue-jumping the waiting lists in the public system for elective surgical and specialty procedures and on better accommodations (seminprivate or private rooms, first in public hospitals and subsequently in private hospitals). In 1996, individual tax-deductible premiums ranged from $294 to $1190 a year for the smallest to the most luxurious upgrades offered by plans A through E. The vast majority of citizens chose plan B, discounted through group policies where they worked. This plan costs them $278 a year after taxes, about the same as a modest weekend getaway for two in Dublin. About 40% of the population have chosen to buy Voluntary Health Insurance Board upgrade policies.

American analysts might well predict that such upgrades would siphon off middle-class support for the public system, causing it to deteriorate into a welfare system with the low level of care that existed under the 19th-century poor laws and dispensaries. However, the national service is widely regarded as good and as having become steadily better over the past several years. At the same time, the public system has become dependent on Voluntary Health Insurance Board upgrades to induce a large minority of the population to pay for most of their medical care above and beyond taxes.

Implicitly, the Insurance Act of 1994 alters the Voluntary Health Insurance Board's relationship with the Department of Health. As indicated by its origins, the board has long been regarded as an extension of the Department of Health ("an arm of government social policy," as a previous department secretary termed it). In a similar vein, although the board's services and costs remain highly dependent on the Department of Health, the 1994 act embodies a shift to making the board one in a field of independent competitors. If it retains its interdependence with the Department of Health, either the board has advantages that make real competition impossible for any outside company or it is fettered and cannot compete effectively (or a bit of both). The Department of Health and the government seem deeply ambivalent: they want competition, but not in any form that might threaten the national system or the Voluntary Health Insurance Board.

**Policy Crisis**

The regulations of the act were not developed until 1996. Soon afterward, however, the dominant insurer in Britain's risk-rated private market, and one of Europe's largest health insurers, launched a marketing blitz for its age-graded policies. The day after the launch, 2500 people called the insurer's telephone sales center for applications, and some of the press dutifully published the company's promotion materials without critical review. The British Union Provident Association's policies appeared to be designed to compete head to head with each of the Voluntary Health Insurance Board's 5 policies; while the basic policy was community rated, however, the premiums for upgrades were age graded. Because they paid cash instead of providing upgraded services, these "cash plans," according to the British Union Provident Association (hereafter "the Union"), were not insurance and therefore not covered by the Health Insurance Act.

Comparisons of the after-tax group premiums of the Voluntary Health Insurance Board's most popular plan (plan B) with the Union's competing policy indicate that the latter's premiums were 10% lower for subscribers less than 19 years of age, 4% lower for subscribers 19 to 49 years of age, 20% higher for people 50 to 54 years of age, and 28% higher for those more than 54 years of age. The Union apparently intended to compete not primarily by being more efficient or providing better service, but by drawing younger subscribers from the Voluntary Health Insurance Board. Moreover, this competition among insurers was not aimed at addressing the real sources of waste in the hospital-centered delivery system.

The Irish case raises basic questions about whether the European Union is clear about what it wants to accomplish with its directive for insurer competition, as distinct from provider competition. The Voluntary Health Insurance Board was already a very efficient insurer, spending only 2% of premiums on administration (vs 12% for the Union). Is this a case in which "efficient insurers might be driven out of the market by inefficient insurers who are successful in cream skimming... so there is no social gain... [but] only social welfare losses?" Moreover, by paying out almost all premiums for patient care, the Voluntary Health Insurance Board had not built up a surplus or reserves, while the Union's lower payout for clinical services had enabled it to accumulate nearly $1 billion in reserves. Thus, the Union could sustain losses for years, while any significant shift of younger subscribers would quickly drive the Voluntary Health Insurance Board toward bankruptcy unless it started to risk rate as well.

Once risk and experience rating begins, it undermines community rating. To have an "open market" in which both approaches exist is to spell the end of community rating. That is the policy lesson from the American decision after World War II to allow commercial insurers to risk-rate groups alongside the community-rated policies of BlueCross BlueShield. Moreover, risk rating by age is only the beginning; competition rewards moving to risk rating by disease and by specific medical or genetic risks.

**Counteroffense**

On November 20, 1996, Voluntary Health Insurance Board chairman Noel Hanlon wrote the minister for health, Michael Noonan, that the Union's policies were "a deliberate attempt to undermine and circumvent the objectives of community rating in the Health Insurance Act of 1994." More darkly, he pointed out that higher premiums for older citizens would lead them to drop their private insurance and "cause large numbers of high risk persons to fall back upon the public system." It was urgent, he continued, that the Department of Health determine whether the Union's cash plans would be allowed to prevail, because they would have "serious consequences for both [the board] and the overall Irish Health Care System."

In various documented remarks, the minister said he would defend community rating and review the Union's policies, but he also said that he welcomed competition, "which has the potential to benefit our market greatly" (speech delivered on November 20, 1996). As is often the case, what kinds of benefits, and by what means, were not articulated.

On December 8, the *Sunday Business Post* sought permission to publish an excerpt from a speech about competition in American health insurance delivered in Dublin the previous October to the Association Internationale de la Mutualité, an international association of health insurers in 30
nations dedicated to community rating and solidarity.13 The Post titled the excerpt "An Unhealthy Tale of Immorality." It described how risk-rated policies had drawn off younger groups and eroded the community-rated base of BlueCross plans until they were forced to engage in risk and experience rating themselves.14 Two days later, the minister reiterated his support of community rating and, soon after, issued a letter of concern to the Union. Legislators became increasingly restive, but the minister continued to fence-sit, saying he would "decide what further action, if any, is warranted in this matter when [the Union] responds to this communication" (written communication, December 1996).

Meanwhile, the Voluntary Health Insurance Board had devised a multipronged plan to stop the Union from selling its risk-rated products. It hired an effective lobbyist and began an intensive legal analysis of the Union's policies. It began to discuss legislation that would tighten gaps in the existing law. It hired a consulting firm in public relations and developed several themes: that competition is fine so long as it benefits the Irish people and is fair, that the Union's policies are integrated products that harm the board and the national health system, and that the Union's policies undermine family values and solidarity. Moreover, vague and dangerous language was found in the Union's terms for its community-rated essential plan. For example, preexisting conditions were excluded and defined as "any disease, illness or injury which began before the person . . . started . . . membership."15 Also, according to the Union's rules, it would pay benefits only in relation to diagnoses and treatments accepted by medical standards "as well as to all the circumstances relevant to the person" — a phrase that seems to invite discriminatory coverage. Furthermore, the rules stated that the Union would not pay for "treatment, the main purpose or effect of which is to relieve symptoms commonly associated with any bodily change arising from . . . causes such as aging, menopause or puberty and which is not due to any underlying disease, illness or injury."

On December 20, the minister finally announced that the Union's schemes "may present difficulties as regards the principle of community rating" and that the cash plans are part of "an integrated insurance package" that may contravene the Health Insurance Act of 1994 (press release, December 20, 1996). In a separate action, the attorney general informed the minister that the policies "were in breech of community rating legislation."16 The Union's strategy to define the age-rated cash plans as not insurance and thus outside the level playing field created by the Health Insurance Act had suffered a setback; however, its managing director insisted that the Union's policies were not illegal and said that he "was absolutely confident of the total legality of the organization's position." The Voluntary Health Insurance Board's chairman said that if younger people switched to the Union's cheaper policies, premiums for those more than 50 years of age could triple in 5 years. "That's what happened in the United States," he added, alluding to D.L.'s December 8 excerpt.14 The Times wrote that the Union "is discriminating against the elderly and forcing American-style health insurance on Ireland."17 As is often the case in Europe, American health insurance and the American health care system serve as an example of how much more costly and inequitable health care can be.

Despite the minister's announcement, nothing formally changed, but the pressure did not diminish during the Christmas season. Garret FitzGerald, the much-revered former prime minister, was moved to publish a prominent essay on December 28 stating that the Union cash plans were a "very thinly disguised" way to "evade" the community rating safeguards that would prove "disastrous" for the Voluntary Health Insurance Board (since three quarters of its members are less than 50 years of age) and "fatal for our health service."18

Nevertheless, sales of the policies began on schedule on January 1. The Consumers' Association of Ireland and the Irish Patients' Association attacked the minister for, in effect, being the sole stockholder of the Voluntary Health Insurance Board as well as the regulator of the market, and they called for him to relinquish his role as regulator so that an independent regulator could defend community rating.19 Thousands of consumers interested in the Union's policies were left in a no-man's-land, "a far cry from the government's idea of rejuvenating Irish health insurance market through competition."20 Senior government officials expressed embarrassment at the minister's slow response and indecision, and the spokeswoman on health for the legislature said that the minister had handled the affair "disgracefully." Then the Sunday Business Post discovered that the Union had chosen not to submit its policies for prior review before its high-profile launch in November,21 which suggested that the Union had decided to use a blitzkrieg strategy to blast past objections and get its policies on the market, because once in place they would be very hard to remove.

On January 9, the Irish Times published an analysis by an American expert that concluded: "If you believe in fair competition that rewards better value rather than cherry-picking, you need to stop all forms of risk rating before they begin."22 The analysis described the many direct and indirect methods of risk rating and averred that "American insurers could drive a herd of Texas long-horns through the vague phrases of the 1994 Act." This echoed the Irish saying that one can "drive a coach-and-four" through something, and later that day journalists pressed the Irish minister to answer questions about driving Texas longhorns through the act, which seemed to butt the minister off his fence. That evening he issued a strict warning that the Union could not issue "packages" that discriminated against the elderly or ill and that, if it did, it could lose its license to trade.23 (Of course, these policies had already been issued and were for sale.) A week later, the minister announced an "agreement" with the Union that it would withdraw its age-rated policies. He also established an independent review group to investigate loopholes or flaws in the community-rated structure of the market (press release, January 17, 1997). The campaign to stop the invasion of risk-rated policies and destroy community rating had succeeded, a rare event in health policy.

Policy Implications

The Irish people and their elected officials have shown moral and policy leadership in attempting to establish rules so that competition in health insurance rewards greater efficiency rather than discrimination against older and sicker citizens. But the law and regulations still leave room for community-rated competitors to discriminate. Beyond that, the entire community-rated system, and the social justice it embodies, will soon collapse unless strategic adjustments are made that reward the young for signing up and staying in and "punish" older people for not signing up until they are 50 or 55 years old. There are several equitable techniques for dampening these effects, such as age-of-entry community rates and lifetime community rates.

Since the European Union directive is silent about community rating or creating a level playing field, is it possible that its authors find discrimination by age and risk acceptable? Do they wish countries to violate the first five "benchmarks of fairness" that characterize a health insurance system in a just society?24 This question needs serious and public debate. Given the difficulty of creating a level playing field in health insurance and the small administrative

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overheads of large insurance systems such as the Voluntary Health Insurance Board, one wonders whether the European Union will increase inefficiency with its directive requiring competition in health care. The major expenses and potential for lowering costs lie in how services are provided, and provider competition may be what the European Union is seeking, although policymakers need to consider evidence from several countries that provider competition increases costs and inequities.\(^{25-27}\)

In a word, health care does not meet many of the requirements for neoclassical competition, so that high transaction costs, fragmentation, privatization, profiteering, and discrimination can result.\(^{28}\)

The rising premiums of the Voluntary Health Insurance Board, for example, are not due to its being inefficient, and competition will raise its overhead costs. Rather, the board’s cost problems stem from its being piggy-backed on the organization, culture, financing, and structure of the public system run by the Department of Health, and both are strongly centered on hospital-based, specialized services. For example, the department added considerably more consultants (senior subspecialists) to the system and increased hospital charges, forcing the board’s costs to rise faster than would have been the case otherwise.\(^{8}\) Thus, the board was in a no-win position between the resulting cost spiral and the need to minimize premium increases to keep down political unrest among its subscribers. As a result, the board’s operating losses have exceeded projections for several years, depleting an earlier reserve fund and causing the board to come precariously close to not meeting its solvency requirements in what has been characterized as a “financial meltdown.”\(^{29}\)

Yet, keeping premiums below the costs of medical services won no friends among subscribers. Moreover, as supplementary upgrades that pay significantly more to doctors, the board’s policies exacerbate cost increases with strong incentives for doctors to hospitalize patients more frequently and to do more tests and procedures. It is a kind of “wallet biopsy” in reverse, in which providers check to see whether patients have a private insurance card and then increase tests, procedures, and fees if they do.

In short, substantial solutions to the Voluntary Health Insurance Board’s underlying problems of rising costs and overuse of hospital-based services will require its working with the Department of Health to develop a cost-effective restructuring of the entire Irish health care system.

References